		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024992

Facility Name: FAIRVIEW NURSING CENTER

Address: 602 EAST JACKSON STREET (Number) DUQUOIN (City) 62832 (Zip Code)

County: PERRY

Telephone Number: (618) 542-3441 **Fax #** (618)542-6351

IDPA ID Number: 370923910001

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MANAGEMENT CORP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,132	6,641		22,773	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,132	6,641		22,773	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.87%

D. How many bed-hold days during this year were paid by Public Aid?
3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/10/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary NOT APPLICABLE

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	91,808	5,340	5,445	102,593		102,593		102,593			1
2	Food Purchase		70,160		70,160	3,350	73,510	(350)	73,160			2
3	Housekeeping	60,127	8,099		68,226	(298)	67,928		67,928			3
4	Laundry	45,309	6,826		52,135		52,135		52,135			4
5	Heat and Other Utilities			40,103	40,103	272	40,375		40,375			5
6	Maintenance	19,633	10,248	19,540	49,421		49,421		49,421			6
7	Other (specify):*											7
8	**TOTAL General Services**	216,877	100,673	65,088	382,638	3,324	385,962	(350)	385,612			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	568,696	22,077	420	591,193	(2,031)	589,162		589,162			10
10a	Therapy	23,499		5,237	28,736		28,736		28,736			10a
11	Activities	28,194	1,947	2,160	32,301	(928)	31,373		31,373			11
12	Social Services	18,406		2,160	20,566		20,566		20,566			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	638,795	24,024	9,977	672,796	(2,959)	669,837		669,837			16
	C. General Administration											
17	Administrative	42,714		6,677	49,391	36,488	85,879		85,879			17
18	Directors Fees											18
19	Professional Services			120,195	120,195	(65,674)	54,521	(50,625)	3,896			19
20	Dues, Fees, Subscriptions & Promotions			8,666	8,666	94	8,760	(1,757)	7,003			20
21	Clerical & General Office Expenses	19,788	6,273	6,320	32,381	16,903	49,284	(200)	49,084			21
22	Employee Benefits & Payroll Taxes			133,198	133,198	5,309	138,507		138,507			22
23	Inservice Training & Education			139	139		139		139			23
24	Travel and Seminar			2,703	2,703	124	2,827		2,827			24
25	Other Admin. Staff Transportation					1,009	1,009		1,009			25
26	Insurance-Prop.Liab.Malpractice			8,324	8,324	651	8,975		8,975			26
27	Other (specify):*											27
28	**TOTAL General Administration**	62,502	6,273	286,222	354,997	(5,096)	349,901	(52,582)	297,319			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	918,174	130,970	361,287	1,410,431	(4,731)	1,405,700	(52,932)	1,352,768			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIRVIEW NURSING CENTER #0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			21,354	21,354	1,695	23,049	34,575	57,624			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							16,997	16,997			32
33	Real Estate Taxes			12,982	12,982		12,982		12,982			33
34	Rent-Facility & Grounds			44,828	44,828	3,036	47,864	(44,828)	3,036			34
35	Rent-Equipment & Vehicles			1,092	1,092		1,092		1,092			35
36	Other (specify):*											36
37	**TOTAL Ownership**			80,256	80,256	4,731	84,987	6,744	91,731			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,422		3,422		3,422		3,422			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,724	41,724		41,724		41,724			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		3,422	41,724	45,146		45,146		45,146			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	918,174	134,392	483,267	1,535,833		1,535,833	(46,188)	1,489,645			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,667	30		9
10	Interest and Other Investment Income	(8,175)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(350)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(200)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,302)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(455)	20		28
29	Other-Attach Schedule SEE PG 5A	(133)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 10,852		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(57,040)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (57,040)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (46,188)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIRVIEW NURSING CENTER

ID# 0024992

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29 SCHEDULE VI	$		1
2	2ND YEAR OF IDPH LICENSE FEE PAID IN 1999	200	20	2
3	LEGAL FEES ON DELINQUENT ACCOUNT	(333)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(133)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(350)	0	0	0	0	0	0	0	0	0	0	(350)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(350)	0	0	0	0	0	0	0	0	0	0	(350)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(333)	(50,292)	0	0	0	0	0	0	0	0	0	(50,625)	19
20	Fees, Subscriptions & Promotions	(1,757)	0	0	0	0	0	0	0	0	0	0	(1,757)	20
21	Clerical & General Office Expenses	(200)	0	0	0	0	0	0	0	0	0	0	(200)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,290)	(50,292)	0	0	0	0	0	0	0	0	0	(52,582)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,640)	(50,292)	0	0	0	0	0	0	0	0	0	(52,932)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	21,667	12,908	0	0	0	0	0	0	0	0	0	34,575	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,175)	25,172	0	0	0	0	0	0	0	0	0	16,997	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(44,828)	0	0	0	0	0	0	0	0	0	(44,828)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	13,492	(6,748)	0	0	0	0	0	0	0	0	0	6,744	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,852	(57,040)	0	0	0	0	0	0	0	0	0	(46,188)	45

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		FAIR ACRES NURSING HOME	DUQUOIN			
		SENIOR MANOR NURSING HOME	SPARTA	Jamestown Mgmt Corp	Carbondale	Management
		THREE SPRINGS LODGE	CHESTER	Fairview Residential	DuQuoin	Owns building
		CANTERBURY MANOR NURSING CENTER	WATERLOO	Center Land Trust		
		FREEBURG CARE CENTER	FREEBURG			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 116,113	JAMESTOWN MANAGEMENT CORPORATION	100.00%	$ 65,821	$ (50,292)	1
2	V	30	DEPRECIATION		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	12,908	12,908	2
3	V	34	RENT	44,828	FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%		(44,828)	3
4	V	20	ADMINISTRATIVE FEES		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%			4
5	V	32	INTEREST EXPENSE		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	25,172	25,172	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 160,941			$ 103,901	$ * (57,040)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	****OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT							****	$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Jamestown Management Corporation
Street Address: 1001 E Main
City / State / Zip Code: Carbondale, IL 62901
Phone Number: ((618) 549-8331
Fax Number: ((618) 549-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158		$ 7,064	$	2,088	$ 812	1
2	5	UTILITIES	HOURS OF SERVICE	18,158		2,367		2,088	272	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,440		317,177	317,177	1,201	36,488	3
4	19	LEGAL AND ACCOUNTING	HOURS OF SERVICE	18,158		1,280		2,088	147	4
5	20	LICENSE AND DUES	HOURS OF SERVICE	18,158		816		2,088	94	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	7,718		121,881	121,881	888	14,023	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	18,158		18,791		2,088	2,161	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	18,158		46,167		2,088	5,309	8
9	24	SEMINARS	HOURS OF SERVICE	10,440		1,077		1,201	124	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	10,440		8,770		1,201	1,009	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		5,657		2,088	651	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		14,736		2,088	1,695	12
13	33	REAL ESTATE	HOURS OF SERVICE	18,158		0		2,088	0	13
14	34	RENT	HOURS OF SERVICE	18,158		26,400		2,088	3,036	14
15										15
16										16
17		**EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN								17
18		ELIMINATED PRIOR TO COST REPORT								18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 572,183	$ 439,058		$ 65,821	25

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANTERR BANK		X	FINANCE CONSTRUCTION	$2,666.00	03-01-99	$ 310,000	$ 297,205	03-01-04	0.0825	$ 25,172	1
2	OF CHRISTOPHER											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,666.00		$ 310,000	$ 297,205			$ 25,172	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 310,000	$ 297,205			$ 25,172	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRVIEW NURSING CENTER **#** 0024992 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	11,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	12,982	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,382	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	11,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	12,982	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	11,034	8
	1996	11,077	9
	1997	11,227	10
	1998	12,785	11
	1999	12,982	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,460 B. General Construction Type: Exterior BRICK Frame WOOD & CONCRET Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING	76,230	1968	$ 3,996	1
2					2
3	TOTALS	76,230		$ 3,996	3

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1968	1968	$ 94,863	$	40	$ 2,372	$ 2,372	$ 77,603	4
5			1968	1968	61,381		20			61,381	5
6			1970	1970	3,953		20			3,953	6
7	18		1970	1970	26,047		38	685	685	21,064	7
8	16		1976	1976	177,922		30	5,931	5,931	146,793	8
	Improvement Type**										
9	FIRE ALARM			1981	1,190		10			1,190	9
10	SEWER LINE			1982	1,056		10			1,056	10
11	PLUMBING IMPROVEMENTS			1984	1,193		10			1,193	11
12	ROOF & LANDSCAPING			1984	1,488		10			1,488	12
13	ACTIVITY ROOM			1986	15,306		20	765	765	11,284	13
14	ACTIVITY ROOM			1987	5,223		20	261	261	3,719	14
15	ROOF & LANDSCAPING			1987	9,775		10			9,775	15
16	PARKING LOT			1987	18,960		15	1,264	1,264	17,380	16
17	SECURITY SYSTEM			1988	2,583		15	172	172	2,150	17
18	RENOVATIONS			1989	2,723		15	182	182	2,184	18
19	HOT WATER HEATER			1990	4,128		15	275	275	2,888	19
20	6 WALL A/C UNITS			1990	7,205		8			7,205	20
21	LANDSCAPING			1990	495		10	20	20	495	21
22	SHOWERS/ CUBICLE TRACKS			1990	8,459	119	15	564	445	5,922	22
23	ROOF			1990	13,831	439	25	553	114	5,807	23
24	TELEPHONE			1991	3,274		20	164	164	1,558	24
25	WATER HEATER			1991	1,945		15	130	130	1,235	25
26	EMERGENCY LIGHTS			1992	960		15	64	64	544	26
27	SEAL & STRIPE PARKING LOT			1994	1,421		5			1,421	27
28	EMERGENCY LIGHTS			1995	994		15	99	99	545	28
29	HOT WATER HEATER			1995	7,433		15	496	496	2,728	29
30	SUBPANELS & CIRCUITS INSTALLED TO A/C			1996	2,394	239	10	240	1	1,080	30
31	PTAC UNIT			1996	1,163	116	10	116		522	31
32	A/C UNIT			1996	1,071	107	10	107		482	32
33	INSTALLED SERVICE CABLE			1997	7,666	511	15	511		1,789	33
34	A/C UNITS			1998	698	122	10	70	(52)	175	34
35	HOT WATER HEATER			1998	2,985	522	15	199	(323)	498	35
36	TOTAL (lines 4 thru 35)				$ 489,785	$ 2,175		$ 15,240	$ 13,065	$ 397,107	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	OVERBED LIGHTING			1998	8,932	1,562	15	595	(967)	1,488	9
10	CARPET			1998	588	103	5	118	15	295	10
11	BASBOARD HEATING			1998	3,599	629	15	240	(389)	600	11
12	CABINETS & COUNTERTOPS			1998	708	124	5	142	18	355	12
13	WALLPAPER & INSTALLATION			1998	9,457	1,654	5	1,891	237	4,728	13
14	PAINTING			1998	11,779	2,060	5	2,356	296	5,890	14
15	Trims, pictures, mirrors, permanent decorative fixtures			1998	2,007	351	5	401	50	1,003	15
16	FLOOR COVE BASE			1998	901	158	5	180	22	450	16
17	MORTON STORAGE BUILDING			1998	3,917	124	15	261	137	392	17
18	BUILDING ADDITION			1998	239,137		15	15,942	15,942	23,913	18
19	PARKING LOT			1998	13,916		15	928	928	2,320	19
20	FLOORING - ADJUSTMENT TO 1998 BLDG ADDITION			1999	737		5	147	147	221	20
21	DOOR ALARM SYSTEM			1999	6,691		10	669	669	1,004	21
22	WALLPAPER & PAINTING			1999	8,314	1,663	5	1,663		2,494	22
23	INSTALL BOOKCASE IN ADMIN OFFICE			1999	333	67	10	66	(1)	99	23
24	LANDSCAPING			1999	5,931	593	10	593		890	24
25	SEAL COATED & STRIPED PARKING LOT			1999	1,646	206	8	206		309	25
26	INSTALL TELEPHONES IN BREAKROOM & DINING			1999	777	155	5	155		233	26
27	MOVE PHONE LINES			1999	328	66	5	67	1	100	27
28	ENTRANCE SIGN			1999	1,000	200	5	200		300	28
29	PAINT WINDOW GRIDS			1999	175	35	5	35		53	29
30	INSTALLATION OF FLOORING			1999	8,949	895	10	895		1,342	30
31	FOUNTAIN AND LIGHT			1999	1,774	355	5	355		532	31
32	Balance of trims, pictures, mirrors, permanent decorative fixtures			1999	3,952	190	5	790	600	1,185	32
33	to refurbish the building.										33
34	AWNINGS			1999	420	103	5	84	(19)	126	34
35											35
36	TOTAL (lines 4 thru 35)				$ 335,968	$ 11,293		$ 28,979	$ 17,686	$ 50,322	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Labor & materials to remove existing wall and rebuild			1999	8,559	856	10	856		1,284	9
10	new wall, relocate plumbing, & electrical services, install										10
11	cabinetry & countertops, and installed new tile flooring.										11
12	Labor & materials to gut an existing bathroom and rehab										12
13	room to create 2 new bathrooms, and storage areas										13
14	for housekeeping and dietary (to be completed in 2000).										14
15	Labor & materials to install new cabinetry, relocate										15
16	plumbing & electrical services, repair drywall & paint										16
17	the breakroom.										17
18											18
19	Labor & materials to complete 1999 bathroom project.			2000	20,296	1,015	10	1,015		1,015	19
20	Installed ceramic tile, sinks, toilet stools, showers, and										20
21	lighting fixtures.										21
22											22
23	Labor & material to remove existing wall in order to convert										23
24	storage room into a resident room. Removed existing closets, installed			2000	11,212	561	10	561		561	24
25	shower area, relocated doors, electrical, and plumbing services,										25
26	repaired and painted drywall, & relocated call lights.										26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 40,067	$ 2,432		$ 2,432	$	$ 2,860	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 93,197	$ 2,906	$ 8,095	$ 5,189		$ 54,436	37
38	Current Year Purchases	20,788	2,548	1,183	(1,365)		1,883	38
39	Fully Depreciated Assets	140,087					140,087	39
40								40
41	TOTALS	$ 254,072	$ 5,454	$ 9,278	$ 3,824		$ 196,406	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	JAMESTOWN ALLOCATION			$	$ 1,695	$ 1,695	$		$ 8,504	42
43										43
44										44
45										45
46	TOTALS			$	$ 1,695	$ 1,695	$		$ 8,504	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,123,888	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 23,049	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 57,624	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 34,575	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 655,199	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	PARKING LOT 1968	$ 3,720	$	$ 3,720	52
53	ROOF 1968	7,440		7,440	53
54	FIRE ALARM 1969	130		130	54
55	EQUIPMENT VAR	24,719		24,719	55
56	Assets no longer in use (obsolete)				56
57	TOTALS	$ 36,009	$	$ 36,009	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE (included in costs)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 1,092 Description: dish service 828; storage 114; wheelchair 150
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
   We only hire trained aides.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): oxygen	39/2					3,422		3,422	13
14	TOTAL			$		$	$ 3,422		$ 3,422	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 77,413	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	182,196		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	36,419		5
6	Prepaid Insurance	12,225		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): investment	6,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 314,253	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	72,711		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	368,537		16
17	Accumulated Depreciation (book methods)	(311,599)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 129,649	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 443,902	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 27,326	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,858		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,281		31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,600		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 78,065	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 78,065	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 365,837	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 443,902	$	48

***(See instructions.)**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 414,986	1
2	Restatements (describe):		2
3	1999 ILLINOIS REPLACEMENT TAX	(1,351)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 413,635	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	115,555	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) EXCESS SALARIES ELIMINATED	(13,353)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (47,798)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 365,837	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,643,213	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,643,213	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,175	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,175	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,651,388	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	382,638	31
32	Health Care	672,796	32
33	General Administration	354,997	33
	B. Capital Expense		
34	Ownership	80,256	34
	C. Ancillary Expense		
35	Special Cost Centers	3,422	35
36	Provider Participation Fee	41,724	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,535,833	40
41	**Income before Income Taxes (line 30 minus line 40)****	115,555	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 115,555	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.** **IL Replacement Tax w**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,714	1,933	$ 36,758	$ 19.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,730	4,227	61,166	14.47	3
4	Licensed Practical Nurses	10,712	11,497	136,868	11.90	4
5	Nurse Aides & Orderlies	36,743	38,929	330,551	8.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,674	1,924	23,499	12.21	8
9	Activity Director	2,709	2,962	28,194	9.52	9
10	Activity Assistants					10
11	Social Service Workers	1,761	1,919	18,406	9.59	11
12	Dietician					12
13	Food Service Supervisor	2,086	2,175	17,452	8.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,691	9,264	74,356	8.03	15
16	Dishwashers					16
17	Maintenance Workers	1,859	1,965	19,633	9.99	17
18	Housekeepers	6,415	7,045	60,127	8.53	18
19	Laundry	4,058	4,906	45,309	9.24	19
20	Administrator	1,872	2,084	42,714	20.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,857	2,008	19,788	9.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) WARD CLERK	448	464	3,353	7.23	33
34	TOTAL (lines 1 - 33)	86,329	93,302	$ 918,174 *	$ 9.84	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	108	$ 5,445	L1/C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		420	L10/C3	39
40	Physical Therapy Consultant	94	5,148	L10A/C3	40
41	Occupational Therapy Consultant	1	59	L10A/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	30	L10A/C3	43
44	Activity Consultant	42	2,160	L11/C3	44
45	Social Service Consultant	42	2,160	L11/C3	45
46	Other(specify) PURCHASING		1,058	L19/C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	$ 16,480		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM SCHRAMKE	Current Administrator	0	$ 12,222
GREG HECK	Administrator	0	30,492
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 42,714

B. Administrative - Other

Description	Amount
BONUS TO MANAGEMENT COMPANY EMPLOYEES	$ 6,677
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 6,677

C. Professional Services

Vendor/Payee	Type	Amount
Jamestown Management Corp	Management	$ 116,113
Mikron	Computer Service	1,023
ADP	Payroll	570
Barnett & Levine	Accounting	698
M.E.S.	Purchasing	1,058
Benefit Planning Consultants	401k Services	400
Gayl Pyatt	Legal	333
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 120,195

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,992
Unemployment Compensation Insurance	12,896
FICA Taxes	70,240
Employee Health Insurance	8,218
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	90
Vaccines	1,347
401k Employer Match	3,129
Staff parties, attendance, awards, ect.	6,286
Jamestown Allocation	5,309
TOTAL (agree to Schedule V, line 22, col.8)	$ 138,507

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,421
Health Care Worker Background Check	612
(Indicate # of checks performed 51)	
Other Advertising	1,757
Subscriptions 344; Jamestown Allocation 94	438
NAGNA 1825; Chamber of Commerce 200	2,025
Corporation fees	262
INHAA 75; Sam's Club 20; CLIA 150	245
Less: Non-allowable membership	(200)
Less: Public Relations Expense	(1,302)
Non-allowable advertising	( )
Yellow page advertising	(455)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,003

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Local mileage	736
Seminar Expense	1,967
Jamestown Allocation	124
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,827

**See instructions.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	1994	$ 2,816	3	$ 469	$	$	$	$	$	$	$	$
2	PAINTING	1996	1,784	3	595	595	297						
3													
4													
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18													
19													
20	TOTALS		$ 4,600		$ 1,064	$ 595	$ 297	$	$	$	$	$	$

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,724**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRVIEW NURSING CENTER INC
RECLASSIFICATIONS ON DPA COST REPORT 12/31/00
PAGES 3&4 COLUMN 5

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASE	2422	
10	NURSING & MEDICAL RECORDS		2422
	RECLASSIFY FOOD SUPPLEMENTS		
21	CLERICAL & GENERAL OFFICE EXP	719	
10	NURSING & MEDICAL RECORDS		719
	RECLASSIFY OFFICE SUPPLIES		
2	FOOD PURCHASE	928	
11	ACTIVITIES		928
	RECLASSIFY FOOD PURCHASED FOR ACT DEPT		
10	NURSING & MEDICAL RECORDS	1110	
3	HOUSEKEEPING		1110
	RECLASSIFY SOAP AND SHAMPOO		
VAR	VARIOUS LINE ITEMS	65821	
19	PROFESSIONAL SERVICES		65821
	SEE SCHEDULE VIII FOR BREAKDOWN		